New Hampshire Board of Medicine

121 SOUTH FRUIT STREET, CONCORD, NH 03301-2412
Tel. (603) 271-1203 Fax (603) 271-6702
TDD Access: Relay NH 1-800-735-2964
WEB SITE: www.nh.gov/medicine

PHYSICIAN ASSISTANT REINSTATEMENT APPLICATION

FEE: $115.00 (check made payable to: Treasurer, State of New Hampshire.)

NAME:_____
(LAST) (FIRST) (MIDDLE) (MAIDEN)

HOME ADDRESS:_____

HOME PHONE NUMBER:_____

EMAIL ADDRESS:_____

EMPLOYMENT SINCE REGISTRATION LAPSED:

_____

_____

_____

PROSPECTIVE EMPLOYER IN NEW HAMPSHIRE: (You must have a RSP Supervisory Form corresponding with this section.)

_____

_____

STATES OTHER LICENSES/CERTIFICATION

Please list all states where **you hold or have ever held** licensure/certification and the number. **Please send the enclosed clearance to each state for official verification.**

STATE	**LICENSE/CERTIFICATION #**
_____	_____
_____	_____

RECERTIFICATION FROM NCCPA

A xerox copy of your current pocketcard from NCCPA showing certification date is required.

REFERENCES

Please have two letters of reference submitted from physicians who have served in an advisory capacity to the applicant. Letters must be on letterhead, submitted as originals.

CRIMINAL HISTORY RECORD CHECK

You will receive an acknowledgment letter once your application has been received. This letter will advise you of what information, if any, is outstanding at that time. If you do not receive an acknowledgment letter within 30 days, please contact the Board between 8:00 A.M. and 4:00 P.M. EST. With the acknowledgement letter, you will receive paperwork to complete a criminal background check. **Pursuant to RSA 328-D:3-a, you are required to submit a notarized criminal history record release form, along with a check made payable to the State of New Hampshire-Criminal Records in the amount of $41.50 for Livescan and $51.50 for Inked fingerprints, which authorizes the release of your criminal history record, if any, to the Board. This form will be provided to you with your acknowledgment letter once your application has been received by the Board.**

	YES	NO
1. Have you ever, for any reason, been refused a license or certification by any other licensing or certifying body and if so, the circumstances of the incident?	____	____
2. Have you ever been or have reason to believe that you are, or will soon be, the subject of any kind of disciplinary investigation or action by any hospital, healthcare organization or licensing or certifying body and if so, the nature of the allegations and the subsequent disposition of the action?	____	____
3. Have you ever been convicted of a felony or misdemeanor, and, if so, the name of the court, the details of the offense, the date of conviction and the sentence imposed?	____	____
4. Have you ever been treated for drug or alcohol abuse, or been hospitalized for any mental illness within the year preceding the filing of the application, or have you ever had such treatment or hospitalization for a condition which affected your ability to perform the functions of a physician assistant?	____	____

NOTE: ALL LETTERS ACCOMPANYING THIS APPLICATION MUST BE ORIGINALS ADDRESSED TO THE BOARD OF MEDICINE. WE DO NOT ACCEPT COPIES OF ANY REFERENCE LETTERS.

AFFIDAVIT OF APPLICANT

State of _____

County of _____

_____ of _____
(Applicant) (Address)

being duly sworn says that (s)he is the person referred to in the above application for certification (and photograph below) as a Physician Assistant in the state of New Hampshire; that (s)he is a graduate of an approved program for Physician Assistants; and that all statements herein or attached hereto are each and all true in every respect. Further, (s)he has never been an inmate in an institution for the treatment of insanity, drug addiction or inebriety.

_____
(SIGNATURE OF APPLICANT)

(PHOTO)

Sworn to before me this _____ day of _____, 19___.

(SEAL)

_____
(NOTARY PUBLIC)
MY COMMISSION EXPIRES:_____

****

For Board Use Only:

APPLICATION RECEIVED:_____ FEE:_____

CERTIFICATION #:_____ ISSUED:_____

Licensure Verification Form

New Hampshire Board of Medicine

RELEASE OF INFORMATION FROM OTHER LICENSING AUTHORITIES

I am applying for a license to practice as a physician assistant in the State of New Hampshire. The NH Board of Medicine requires that the following form be completed by each jurisdiction in which I am now or was previously licensed. This constitutes your authority to release any and all information in your files, favorable or otherwise, directly to the NH Board of Medicine. Kindly mail your response to:

BOARD OF MEDICINE
121 SOUTH FRUIT STREET
CONCORD, NEW HAMPSHIRE 03301-2412
Tel: (603) 271-1203

Biographic Information:

_____, P.A.
Last Name First Name Middle Name

_____
Mailing Address City State Zip Code

_____ _____
Social Security Number: Date of Birth:

_____ _____
License Number (if known) Signature

The following should be completed by the licensing authority and returned directly to the NH Board at the address above.

1. Name of Licensing Authority: _____
2. Full Name of Licensee: _____
3. License Number: _____
4. Is License Current? Yes No Expiration Date: _____
5. Is License Restricted? Yes No
6. Previous Disciplinary Action? Yes No
7. Pending Investigations? Yes No

If the answer is yes to questions 5, 6 or 7, please attach supporting information.

Please affix official Board seal here

_____
Signature/Title

_____
Date

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In accordance with RSA 328-D and regulations issued thereunder, I certify that

_____, P.A. assists me professionally and that I assume responsibility for supervision of his/her professional activities.

_____	_____
RSP Signature	ARSP Signature
_____	_____
(Print or type name)	(Print or type name)
_____	_____
(Professional Address)	(Professional Address)
_____	_____
_____	_____
(NH License Number)	(NH License Number)
_____	_____
(Effective Date of Supervision)	(Effective Date of Supervision)